

6763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06756

FOR STATE
HEALTH DEPT.

1. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Charles Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First <u>DANIEL L</u> Middle <u>Mer</u> Last <u>Bowles</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1916</u>
9. AGE (In years last birthday) <u>42</u> Yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u> Hours <u>43</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumberman</u>	
11. BIRTHPLACE (State or foreign country) <u>St Marys Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Webster Bowles</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Buckler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Army</u>		16. SOCIAL SECURITY NO. <u>213-46-2294</u>	
17. INFORMANT <u>Am Virginia Bowles</u>		Address <u>Hughsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRACTURED BASE OF SKULL</u> 9/10.3 DUE TO (b) <u>TREE FELL ON HEAD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>WHILE CUTTING TIMBER</u> INTERVAL BETWEEN ONSET AND DEATH <u>6-17-58</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tree fell on head</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>TREE FELL ON HEAD</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-17-58</u> Hour <u>9</u> a.m. p.m.	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Forest</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edehen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDEHEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-17-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Josephs</u>	22d. LOCATION (City, town, or county) (State) <u>Morgantown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Mc LaPlata</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Edehen</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE STATE
HEALTH DEPT
10

1. NAME OF DECEASED: JOHN J. WOOD

2. SEX: MALE

3. AGE: 45

4. DATE OF BIRTH: 1910

5. PLACE OF BIRTH: NEW YORK

6. OCCUPATION: LABORER

7. MARITAL STATUS: MARRIED

8. EDUCATION: HIGH SCHOOL

9. RELIGION: CATHOLIC

10. RACE: WHITE

11. COLOR: WHITE

12. BUILD: STANDARD

13. HAIR: BROWN

14. EYES: BROWN

15. SKIN: Fair

16. TALLNESS: 5' 8"

17. WEIGHT: 160

18. BLOOD PRESSURE: 120/80

19. HEART: Normal

20. LUNGS: Normal

21. LIVER: Normal

22. SPLEEN: Normal

23. PANCREAS: Normal

24. STOMACH: Normal

25. SMALL INTESTINE: Normal

26. LARGE INTESTINE: Normal

27. BLADDER: Normal

28. KIDNEYS: Normal

29. UTERUS: Normal

30. VAGINA: Normal

31. CERVIX: Normal

32. VULVA: Normal

33. CLITORIS: Normal

34. PENIS: Normal

35. TESTES: Normal

36. PROSTATE: Normal

37. SEMEN: Normal

38. URINE: Normal

39. STools: Normal

40. SWEAT: Normal

41. TEARS: Normal

42. SALIVA: Normal

43. SWEAT GLANDS: Normal

44. TEAR GLANDS: Normal

45. SALIVARY GLANDS: Normal

46. THYROID: Normal

47. PARATHYROID: Normal

48. ADRENAL: Normal

49. PITUITARY: Normal

50. HYPOTHALAMUS: Normal

51. BRAIN: Normal

52. SPINAL CORD: Normal

53. NERVES: Normal

54. MUSCLES: Normal

55. BONES: Normal

56. JOINTS: Normal

57. SKIN: Normal

58. NAILS: Normal

59. HAIR: Normal

60. EYES: Normal

61. EARS: Normal

62. NOSE: Normal

63. MOUTH: Normal

64. THROAT: Normal

65. LARYNX: Normal

66. TRACHEA: Normal

67. BRONCHI: Normal

68. LUNGS: Normal

69. HEART: Normal

70. BLOOD VESSELS: Normal

71. LYMPHATIC SYSTEM: Normal

72. IMMUNE SYSTEM: Normal

73. ENDOCRINE SYSTEM: Normal

74. NERVOUS SYSTEM: Normal

75. MUSCULOSKELETAL SYSTEM: Normal

76. INTEGUMENTARY SYSTEM: Normal

77. REPRODUCTIVE SYSTEM: Normal

78. DIGESTIVE SYSTEM: Normal

79. RESPIRATORY SYSTEM: Normal

80. CIRCULATORY SYSTEM: Normal

81. EXCRETORY SYSTEM: Normal

82. SENSORY SYSTEM: Normal

83. MOTOR SYSTEM: Normal

84. AUTONOMIC SYSTEM: Normal

85. CENTRAL NERVOUS SYSTEM: Normal

86. PERIPHERAL NERVOUS SYSTEM: Normal

87. SOMATIC NERVOUS SYSTEM: Normal

88. VISCERAL NERVOUS SYSTEM: Normal

89. SYMPATHETIC NERVOUS SYSTEM: Normal

90. PARASYMPATHETIC NERVOUS SYSTEM: Normal

91. AUTONOMIC NERVOUS SYSTEM: Normal

92. NERVOUS SYSTEM: Normal

93. MUSCULOSKELETAL SYSTEM: Normal

94. INTEGUMENTARY SYSTEM: Normal

95. REPRODUCTIVE SYSTEM: Normal

96. DIGESTIVE SYSTEM: Normal

97. RESPIRATORY SYSTEM: Normal

98. CIRCULATORY SYSTEM: Normal

99. EXCRETORY SYSTEM: Normal

100. SENSORY SYSTEM: Normal

101. MOTOR SYSTEM: Normal

102. AUTONOMIC SYSTEM: Normal

103. CENTRAL NERVOUS SYSTEM: Normal

104. PERIPHERAL NERVOUS SYSTEM: Normal

105. SOMATIC NERVOUS SYSTEM: Normal

106. VISCERAL NERVOUS SYSTEM: Normal

107. SYMPATHETIC NERVOUS SYSTEM: Normal

108. PARASYMPATHETIC NERVOUS SYSTEM: Normal

109. AUTONOMIC NERVOUS SYSTEM: Normal

110. NERVOUS SYSTEM: Normal

111. MUSCULOSKELETAL SYSTEM: Normal

112. INTEGUMENTARY SYSTEM: Normal

113. REPRODUCTIVE SYSTEM: Normal

114. DIGESTIVE SYSTEM: Normal

115. RESPIRATORY SYSTEM: Normal

116. CIRCULATORY SYSTEM: Normal

117. EXCRETORY SYSTEM: Normal

118. SENSORY SYSTEM: Normal

119. MOTOR SYSTEM: Normal

120. AUTONOMIC SYSTEM: Normal

121. CENTRAL NERVOUS SYSTEM: Normal

122. PERIPHERAL NERVOUS SYSTEM: Normal

123. SOMATIC NERVOUS SYSTEM: Normal

124. VISCERAL NERVOUS SYSTEM: Normal

125. SYMPATHETIC NERVOUS SYSTEM: Normal

126. PARASYMPATHETIC NERVOUS SYSTEM: Normal

127. AUTONOMIC NERVOUS SYSTEM: Normal

128. NERVOUS SYSTEM: Normal

129. MUSCULOSKELETAL SYSTEM: Normal

130. INTEGUMENTARY SYSTEM: Normal

131. REPRODUCTIVE SYSTEM: Normal

132. DIGESTIVE SYSTEM: Normal

133. RESPIRATORY SYSTEM: Normal

134. CIRCULATORY SYSTEM: Normal

135. EXCRETORY SYSTEM: Normal

136. SENSORY SYSTEM: Normal

137. MOTOR SYSTEM: Normal

138. AUTONOMIC SYSTEM: Normal

139. CENTRAL NERVOUS SYSTEM: Normal

140. PERIPHERAL NERVOUS SYSTEM: Normal

141. SOMATIC NERVOUS SYSTEM: Normal

142. VISCERAL NERVOUS SYSTEM: Normal

143. SYMPATHETIC NERVOUS SYSTEM: Normal

144. PARASYMPATHETIC NERVOUS SYSTEM: Normal

145. AUTONOMIC NERVOUS SYSTEM: Normal

146. NERVOUS SYSTEM: Normal

147. MUSCULOSKELETAL SYSTEM: Normal

148. INTEGUMENTARY SYSTEM: Normal

149. REPRODUCTIVE SYSTEM: Normal

150. DIGESTIVE SYSTEM: Normal

151. RESPIRATORY SYSTEM: Normal

152. CIRCULATORY SYSTEM: Normal

153. EXCRETORY SYSTEM: Normal

154. SENSORY SYSTEM: Normal

155. MOTOR SYSTEM: Normal

156. AUTONOMIC SYSTEM: Normal

157. CENTRAL NERVOUS SYSTEM: Normal

158. PERIPHERAL NERVOUS SYSTEM: Normal

159. SOMATIC NERVOUS SYSTEM: Normal

160. VISCERAL NERVOUS SYSTEM: Normal

161. SYMPATHETIC NERVOUS SYSTEM: Normal

162. PARASYMPATHETIC NERVOUS SYSTEM: Normal

163. AUTONOMIC NERVOUS SYSTEM: Normal

164. NERVOUS SYSTEM: Normal

165. MUSCULOSKELETAL SYSTEM: Normal

166. INTEGUMENTARY SYSTEM: Normal

167. REPRODUCTIVE SYSTEM: Normal

168. DIGESTIVE SYSTEM: Normal

169. RESPIRATORY SYSTEM: Normal

170. CIRCULATORY SYSTEM: Normal

171. EXCRETORY SYSTEM: Normal

172. SENSORY SYSTEM: Normal

173. MOTOR SYSTEM: Normal

174. AUTONOMIC SYSTEM: Normal

175. CENTRAL NERVOUS SYSTEM: Normal

176. PERIPHERAL NERVOUS SYSTEM: Normal

177. SOMATIC NERVOUS SYSTEM: Normal

178. VISCERAL NERVOUS SYSTEM: Normal

179. SYMPATHETIC NERVOUS SYSTEM: Normal

180. PARASYMPATHETIC NERVOUS SYSTEM: Normal

181. AUTONOMIC NERVOUS SYSTEM: Normal

182. NERVOUS SYSTEM: Normal

183. MUSCULOSKELETAL SYSTEM: Normal

184. INTEGUMENTARY SYSTEM: Normal

185. REPRODUCTIVE SYSTEM: Normal

186. DIGESTIVE SYSTEM: Normal

187. RESPIRATORY SYSTEM: Normal

188. CIRCULATORY SYSTEM: Normal

189. EXCRETORY SYSTEM: Normal

190. SENSORY SYSTEM: Normal

191. MOTOR SYSTEM: Normal

192. AUTONOMIC SYSTEM: Normal

193. CENTRAL NERVOUS SYSTEM: Normal

194. PERIPHERAL NERVOUS SYSTEM: Normal

195. SOMATIC NERVOUS SYSTEM: Normal

196. VISCERAL NERVOUS SYSTEM: Normal

197. SYMPATHETIC NERVOUS SYSTEM: Normal

198. PARASYMPATHETIC NERVOUS SYSTEM: Normal

199. AUTONOMIC NERVOUS SYSTEM: Normal

200. NERVOUS SYSTEM: Normal

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6764

CERTIFICATE OF DEATH

Reg. Dist. No.

06757

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - HUGHESVILLE				c. LENGTH OF STAY IN 1b 7 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle ELLIOT Last BURLH				4. DATE OF DEATH Month JUNE Day 20 Year 1958			
5. SEX MALE	6. COLOR OR RACE W-U.S.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 17, 1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER-MILLER				10b. KIND OF BUSINESS OR INDUSTRY FARMING (RETIRED)		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME WILLIAM EDWARD BURLH				14. MOTHER'S MAIDEN NAME HENRIETTA GUY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. EDWARD MURPHY: HUGHESVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC HEART DISEASE (CARDIA 420.0 DUE TO FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIO-SCLEROSIS DUE TO (c) ARTERIO-SCLEROTIC TROPHIC ULCERS (LEG)							INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 YEARS 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from JULY , 1951, to JUNE 20 , 1952, that I last saw the deceased alive on JUNE 20 , 1958, and that death occurred at 11:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE JOHN H. GRIFFIN M.D.				ADDRESS (Street, city or town, state) Box 651, HUGHESVILLE, MD.			
DATE SIGNED 6/20/58							
PHYSICIAN'S NAME (Type) JOHN H. GRIFFIN				ADDRESS Box 651, HUGHESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Bryantown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Huntb. Fun. Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE 2 4 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6765 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06758

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Me</u> b. COUNTY <u>Char</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VERNESSA Laverne BURROUGHS</u>		4. DATE Month <u>6</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16 1957</u>
9. AGE (In years last birthday) <u>7</u> yrs. <u>26</u> Months <u>7</u> Days <u>26</u>		10. IF UNDER 1 YEAR Hours <u>7</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lavellyn Burroughs</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Greer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Pisgah Me</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastro Enteritis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>6/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>T. B. McE Church</u>		22d. LOCATION (City, town, or county) (State) <u>T. B. Mead.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Leppla</u>		24a. REC'D BY REGISTRAR <u>13 '58</u>	
ADDRESS <u>Leppla and</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur H. Leppla</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Item 18 Film 230 6-28-58
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6766

06759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DOYLE Middle J. Last CHASE			4. DATE OF DEATH Month June Day 9 Year 1958		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1954	9. AGE (in years last birthday) 4 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Waldorf, Md	
13. FATHER'S NAME Joseph Greenfield			14. MOTHER'S MAIDEN NAME Emily Chase		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Emily Chase, Waldorf, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis 525 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/9/58	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/11/58	22c. NAME OF CEMETERY OR CREMATORY St Peters	22d. LOCATION (City, town, or county) (State) Waldorf, Md		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Huntz Funeral Home, Waldorf, Md.			24a. REC'D BY REGISTRAR DATE JUN 12 '58	24b. REGISTRAR'S SIGNATURE Alb. Smith	

MEDICAL CERTIFICATION

2

2

DP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06760

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		c. LENGTH OF STAY IN 1b DURING WORKING HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —			d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH WILLIAM CHASE			4. DATE OF DEATH Month Day Year June 20 1958		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1902		9. AGE (In years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sawmill Laborer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Willie Chase			14. MOTHER'S MAIDEN NAME Louise Warren		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 213-22-0860		17. INFORMANT Address Catherine Edelen, Bryantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.3 FRACTURE, SKULL, BASAL; MIDDLE DUE TO (b) AND ANTERIOR FOSSAE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) —					INTERVAL BETWEEN ONSET AND DEATH 45 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL FROM STEEP STAIRWAY APPROXIMATELY 15 FEET IN MILL BOILER PLANT STRIKING HEAD ON EDGE OF WOODEN BENCH			
20c. TIME OF INJURY Month, Day, Year 6/20 1958	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SAWMILL		20f. (City or town) (County) (State) HUGHESVILLE, CHARLES, MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John H. Griffin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/21/58	
EXAMINER'S NAME (Type) JOHN H. GRIFFIN		ASSY. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/23/58	22c. NAME OF CEMETERY OR CREMATORY St Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Bryantown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS —		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
				24b. REGISTRAR'S SIGNATURE —	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Residence		Occupation		Cause of Death		Place of Death	
Manner of Death		Medical History		Physical Examination		Mental Examination	
Post-mortem Examination		Toxicology		Microscopic Examination		Bacteriological Examination	
X-ray Examination		Autopsy		Other		Remarks	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06761

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco	
3. NAME OF DECEASED (Type or print) EVANGELINE First Middle Last L. GARDINER		4. DATE OF DEATH Month June Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1915
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Hughesville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Lyon		14. MOTHER'S MAIDEN NAME Isabelle Ching	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT George I. Gardiner, Port Tobacco, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Injury; cerebral concussion 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 8 hours			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While turning from comode in bath tripped & fell, striking occipital protuberance on far side of bath tub.	
20c. TIME OF INJURY Month, Day, Year 12:30 a. m. June 23 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Port Tobacco, Charles, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Griffin EXAMINER'S NAME (Type) JOHN H. GRIFFIN, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/58	
22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		22d. LOCATION (City, town, or county) (State) Bryantown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE JUN 27 '58	
		24b. REGISTRAR'S SIGNATURE Alfred	

6769

CERTIFICATE OF DEATH

Reg. Dist. No.

06762

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Waldorf</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rural</i>		d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Mildred</i> Middle <i>A.</i> Last <i>Hagens</i>		4. DATE OF DEATH Month <i>June</i> Day <i>15</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 15, 1922</i>
9. AGE (In years last birthday) <i>35</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Melvin Shorter</i>	
14. MOTHER'S MAIDEN NAME <i>Lovanda ?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Warren Hagens, Waldorf, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adenocarcinoma of Left Breast & Node Metastasis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 MOS.</i> <i>10 MOS.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>August 17, 1957</i> to <i>June 7, 1958</i> , that I last saw the deceased alive on <i>June 7, 1958</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>J. Parran Jarboe</i> M.D.		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>6-16-58</i>	
PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/18/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Peters</i>	22d. LOCATION (City, town, or county) (State) <i>Waldorf, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt & Funeral Home, Waldorf, Md.</i> ADDRESS		24a. REC'D BY REGISTRAR <i>June 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Overman</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8769

MASSACHUSETTS
BUREAU OF VITAL RECORDS

CONFIDENTIAL

MASSACHUSETTS

Dec 19 1902
James J. Larabee

James J. Larabee
June 12 1902
6-12-02

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6770

CERTIFICATE OF DEATH

Reg. Dist. No. 06763

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Chas.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Phy Mem Hosp</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>ALLAN GWYN HUNGERFORD</i>		4. DATE OF DEATH <i>June 10 1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 6 1882</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Murderer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Equip</i>	
11. BIRTHPLACE (State or foreign country) <i>Chas. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John H Hungerford</i>		14. MOTHER'S MAIDEN NAME <i>Susan Price</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Agnes Hungerford</i>		Address <i>Newburg</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spontaneous intraventricular Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive vascular disease</i> DUE TO (c) <i>years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 da</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Newburg, Charles, Md.</i>	
21. I certify that I attended the deceased from <i>6-3</i> , 1958, to <i>6-10</i> , 1958, that I last saw the deceased alive on <i>6-10</i> , 1958, and that death occurred at <i>4:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V.B. Detton</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>6-10-58</i>	
PHYSICIAN'S NAME (Type) <i>V.B. DETTOR, M.D.</i>		<i>LA PLATA, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>6-13-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>		22d. LOCATION (City, town, or county) (State) <i>Wayside Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archie Mc. La Plata</i>		ADDRESS <i>La Plata</i>	
24a. REC'D BY REGISTRAR <i>W. J. Beach</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6771 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06764

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Byrons Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>MANVILLE</u> Middle <u>Proctor</u> Last		4. DATE OF DEATH <u>6</u> - <u>14</u> 19 <u>58</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-35</u> 22 Yrs.
9. AGE (In years last birthday) <u>22</u> Yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Agness Suray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>240-37-7174</u>	
17. INFORMANT <u>Morris Proctor</u> Address <u>Laplala MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fell from boat or went swimming from boat</u> (c) <u>swimming from boat</u> INTERVAL BETWEEN ONSET AND DEATH <u>6-14-58</u> <u>6-14-58</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> <u>14</u> <u>58</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Not near</u>	20f. (City or town) <u>Indian Head</u> (County) <u>Charles</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>		22d. LOCATION (City, town, or county) <u>Pomfret</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Laplala MD</u>		ADDRESS <u>Indian Head</u>	
24a. REC'D BY REGISTRAR <u>JUN 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Edelen</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6772

CERTIFICATE OF DEATH

Reg. Dist. No.

06765

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Proffitt		4. DATE OF DEATH Month Day Year June 10, 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1958
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Edward Proffitt		14. MOTHER'S MAIDEN NAME Mary Louise Hudson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs. John E. Proffitt, Bryans Road, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 9 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour (a. m.) 6-10-1958 1:40 a. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) La Plata, Charles, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10 , 19 58 , to 6/10 , 19 58 , that I last saw the deceased alive on 6/10/58 , 19 58 , and that death occurred at 11:45 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE V. B. Dettor		DATE SIGNED 6/10/58	
PHYSICIAN'S NAME (Type) V. B. Dettor, M.D.		ADDRESS (Street, city or town, state) La Plata, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-58	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gregory Lee LaPlata		24a. REC'D BY REGISTRAR JUN 13 1958	
ADDRESS La Plata, Md.		24b. REGISTRAR'S SIGNATURE W. T. ...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06768

6773

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOYCE Middle L. Last QUEEN		4. DATE OF DEATH Month June Day 7 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Queen		14. MOTHER'S MAIDEN NAME Louise Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Queen Pisgah Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural and Subarachnoid Hemorrhage due to Rupture of left Tentorium Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 760.0 (c) 245.0 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Birth Injury	
20c. TIME OF INJURY Month, Day, Year Hour 6/14/58 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Charles (County) Maryland (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 6/9/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58	
22c. NAME OF CEMETERY OR CREMATORY St Charles		22d. LOCATION (City, town, or county) Pisgah (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Le Plata		24a. REC'D BY REGISTRAR JUN 13 1958 24b. REGISTRAR'S SIGNATURE W. H. Leitch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6774

Item 9 F41mG231 7-11-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 06767

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Malcolm</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Malcolm</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Julia Wade</u>				4. DATE OF DEATH Month Day Year <u>June 10 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 10, 1877</u>	
9. AGE (In years less birthday) yrs. <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teaching-Retired School Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Hilary H. Wade</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Washington</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Nettie Wade, Nutley, New Jersey</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Demerol Cardio-vascular Heart Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>		21. I certify that I attended the deceased from <u>3-20</u> , 19 <u>58</u> , to <u>June 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-10</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Ruben N. Dobson</u> M.D.		ADDRESS <u>Baltimore</u>		DATE SIGNED <u>June 10 1958</u>			
PHYSICIAN'S NAME (Type) <u>Ruben N. Dobson</u>		ADDRESS <u>Baltimore</u>		DATE SIGNED <u>June 10 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md</u>		ADDRESS <u>Waldorf, Md</u>		24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James</i>		AGE <i>1-10</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 10 1922</i>		PLACE OF DEATH <i>Home</i>	
CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	
OCCUPATION <i>Student</i>		EDUCATION <i>None</i>	
MARRIED <i>No</i>		SINGLE <i>Yes</i>	
PREVIOUS MARRIAGES <i>None</i>		PREVIOUS DEATHS <i>None</i>	
CAUSE OF DEATH <i>Scarlet fever</i>		MANNER OF DEATH <i>Natural</i>	
IMMEDIATE CAUSE <i>Scarlet fever</i>		INTERMEDIATE CAUSE <i>Scarlet fever</i>	
FUNDAMENTAL CAUSE <i>Scarlet fever</i>		PREEXISTING DISEASES <i>None</i>	
DATE OF BIRTH <i>Jan 1 1921</i>		PLACE OF BIRTH <i>Harford</i>	
CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	
OCCUPATION <i>Student</i>		EDUCATION <i>None</i>	
MARRIED <i>No</i>		SINGLE <i>Yes</i>	
PREVIOUS MARRIAGES <i>None</i>		PREVIOUS DEATHS <i>None</i>	
CAUSE OF DEATH <i>Scarlet fever</i>		MANNER OF DEATH <i>Natural</i>	
IMMEDIATE CAUSE <i>Scarlet fever</i>		INTERMEDIATE CAUSE <i>Scarlet fever</i>	
FUNDAMENTAL CAUSE <i>Scarlet fever</i>		PREEXISTING DISEASES <i>None</i>	

15-4457-1-17-22

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6775

CERTIFICATE OF DEATH

Reg. Dist. No.

06768

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laplate</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Welcome</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Boy</i> First Middle Last <i>WARREN</i>		DATE OF DEATH <i>June 8 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-8-58</i>
9. AGE (In years last birthday) yrs. <i>12</i>		IF UNDER 1 YEAR Months Days Hours Min. <i>12</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Godfrey Nelson Warren</i>		14. MOTHER'S MAIDEN NAME <i>Alice Theresa Ball</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Alice Warren</i>	
17. INFORMANT <i>Alice Warren</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (g).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>773.5</i> DUE TO <i>Respiratory Collapse</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>prematurity</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>12 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-8-58</i> to <i>6-9-58</i> , that I last saw the deceased alive on <i>6-8-58</i> , and that death occurred at <i>7:00 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i> M.D.		ADDRESS (Street, city or town, state) <i>Laplate, md</i>	
PHYSICIAN'S NAME (Type) <i>Archard Mc Laplate md.</i>		DATE SIGNED <i>6-10-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-11-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Zion Baptist</i>	22d. LOCATION (City, town, or county) (State) <i>Hill Top md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archard Mc Laplate md.</i>		24a. REC'D BY REGISTRAR <i>JUN 13 '58</i>	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2266214 X VV

CERTIFICATE OF DEATH

I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.	
Signed and sworn to before me this _____ day of _____, 19____.	
My commission expires the _____ day of _____, 19____.	
Notary Public for Maryland.	
I, _____, Registrar of the Health Department, do hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.	
Signed and sworn to before me this _____ day of _____, 19____.	
My commission expires the _____ day of _____, 19____.	
Notary Public for Maryland.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6776

CERTIFICATE OF DEATH

Reg. Dist. No. 06769

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lt. Plate</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wilmington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Thygesen Memorial</i>		1 d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Girl</i> First Middle Last <i>WARREN</i>		4. DATE OF DEATH Month <i>June</i> Day <i>9</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-8-58</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <i>15</i> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Lorrey Nelson Warren</i>		14. MOTHER'S MAIDEN NAME <i>Alice Thekla Bell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Alice Warren</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Collapse</i> 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>prematurity</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>12 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>6-8</i> , 19 <i>58</i> , to <i>6-9</i> , 19 <i>58</i> that I last saw the deceased alive on <i>6-8</i> , 19 <i>58</i> , and that death occurred at <i>9:30</i> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. J. H. L. L. L.</i>		DATE SIGNED <i>6-10-58</i>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-11-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Zion Baptist</i>	22d. LOCATION (City, town or county) (State) <i>Willow Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arehartre Sop. Lanta mo!</i>		24a. REC'D BY REGISTRAR <i>June 13 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Alfred...</i>	

2166214 XV

ARKANSAS STATE DEPARTMENT OF HEALTH—EALINGORE 11